Florida Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10200961	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISCAYNE HEALTH AND REHABILITATION CENTER	12505 NE 16TH AVE , NORTH MIAMI, Florida, 33161

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	INITIAL COMMENTS An unannounced Relicensure survey was conducted at Biscayne Health and Rehabilitation Center on May 11, 2026, through May 14, 2026. Deficiencies were identified at the time of the survey. The following is a description of the non-compliance.	N0000		06/08/2026
N0095 SS = D	Drug Storage CFR(s): 59A-4.112(6), FAC (6) Prescription drugs and non-prescription medications requiring refrigeration must be stored in a refrigerator. The refrigerator must be locked or located within a locked medication room and accessible only to licensed staff. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and interviews, the facility did not adhere to proper medication storage protocols on the second floor, as evidenced by medicated ointments observed in the rooms of Resident #58, Resident #20, and Resident #29. The findings include: 1) Observation on 05/11/2026 at 9:07 AM revealed a container of Diclofenac ointment on top of the sink in Resident # 58's room (Photographic evidence). Review of Resident 58's clinical records revealed the resident was admitted on 07/19/2025 with diagnosis that included: Heart Failure and had no cognitive impairment. 2) Observation on 05/11/2026 at 9:39 AM and on 05/12/2026 at 11:06 AM a tube of Hydrophilic wound dressing was noted in a basket on Resident # 20's nightstand. (Photo evidence). Review of Resident # 20's clinical records revealed the resident was admitted on 07/19/2025 with diagnosis that included: Cerebral infarction due to	N0095	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the terms or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of the Federal and State laws. The facility continues to ensure that all drugs and biologicals are stored appropriately. IMMEDIATE CORRECTIVE ACTION Medications were immediately removed from room for residents #58, #20 and # 29 on 5/11/26. Residents #58, #20 and #29 were not adversely affected by alleged deficient practice. IDENTIFICATION OF OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED All active residents in the facility can potentially be affected by the alleged deficient practice. No residents were adversely affected by the alleged deficient practice. Director of Nursing and/or designee conducted a facility-wide observation audit to ensure that drugs and biologicals are stored appropriately on 05/12/2026. SYSTEMATIC CHANGES The Director of Nursing and/or designee initiated	06/08/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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N0095 SS = D	Continued from page 1 embolism of right middle cerebral artery and was severely cognitively impaired. 3) Observation on 05/11/2026 at 10:54 AM revealed a container of Ciclopirox Topical solution on Resident # 29's nightstand. (Photo evidence). Review of Resident #29's clinical record revealed the resident was admitted on 05/04/2025 with diagnosis that included: Malignant neoplasm of overlapping sites of bladder and had no cognitive impairment. Record review of the facility's policy titled, "Storage of Medications" revised January 2026 revealed Policy: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. On 05/11/2026 at 11:18 AM Staff E, Licensed Practical Nurse (LPN) was made aware of the identified concerns. Staff E LPN stated: "Medications and ointments are kept on the locked cart and not allowed at the bedside. Sometimes family brings them in. We do rounds and remove any ointment at the bedside." On 05/11/2026 at 12:16 PM, the Wound care nurse stated: "I put all the creams, ointments, and medicated nail polish back into the treatment cart after providing treatment." On 05/11/2026 at 1:07 PM, Staff D, Certified Nursing Assistant stated: "When I do rounds, I look to make sure the resident is safe. If I see any objects that can harm the residents like razors or a knife I remove them. If I see medications in the room, I tell the nurse." On 05/11/2026 at 1:25 PM the Assistant Director of Nursing was made aware of the identified concerns and stated: "Residents are not allowed to keep any medications in the room. We keep all medications in the cart for the safety of residents." Class III	N0095	Continued from page 1 ongoing in-service education with staff on standards of drug and biological storage on 05/20/2026. MONITORING Nursing Supervisor and/or designee will conduct random observation audits to ensure drugs and biologicals are stored appropriately, 5 days a week for 1 month, then weekly for 3 months. The Director of Nursing and/or designee will report findings of observation/audits to the quality assurance committee monthly for 4 months to ensure continued substantial compliance.	06/08/2026

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N0101 SS = D	Resident Medical Records CFR(s): 400.141(1)(j), FS; 59A-4.118(2), FAC 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized. 59A-4.118(2) FAC Each medical record must contain sufficient information to clearly identify the resident, his or her diagnosis and treatment, and results. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, records reviewed and interviews the facility failed to document adequate information in the medical records for one (Resident # 62) out of two sampled residents with a pressure ulcer. Staff did not sign the Medication Administration Record for pain medication ordered before wound care on several dates in May 2026 for Resident # 62, even though wound care was provided on those days. Five residents with pressure ulcers lived in the facility at the time of the survey. The findings included: During observation on 05/13/2026 at 10:02 AM of Resident # 62's wound care being performed by the facility's Wound Care Nurse and Resident # 62 denied pain at that time. Record review of Resident # 62's clinical record revealed the resident was admitted to the facility on 11/04/2025 with diagnosis that included but not limited to Peripheral Vascular Disease. Review of Resident # 62's care plans that started on 04/13/2026 and revised on 05/05/2026 for a pressure ulcer with interventions that included:	N0101	The facility continues to ensure that resident's medical records are complete and accurately documented. IMMEDIATE CORRECTIVE ACTION Resident #62 was assessed by Director of Nursing upon notification of surveyor and resident# 62 did not have any adverse outcome related to the alleged deficient practice on 5/13/26. IDENTIFICATION OF OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED All active residents in the facility can potentially be affected by the alleged deficient practice. Director of Nursing and/or designee conducted a comprehensive chart audit to ensure that residents with pain medications were accurately documented on EMAR on 5/15/26. No residents were adversely affected by the alleged deficient practice. SYSTEMATIC CHANGES The Director of Nursing and/or designee initiated ongoing in-service education with clinical staff on standards of accurate medication administration documentation with emphasis on accurate documentation of Pain Medication Refusal. MONITORING Nursing Supervisor and/or designee will conduct random observation audits to ensure accurate documentation of pain medication administration and refusal, 5 days a week for 1 month, then weekly for 3 months. The Director of Nursing and/or designee will report findings of observation/audits to the quality assurance committee monthly for 4 months to ensure continued substantial compliance is achieved and maintained.	06/08/2026

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N0101 SS = D	Continued from page 3 Administer medications and treatments as ordered by the medical doctor. Record review of Resident #62's significant change Minimum Data Set reference dated 04/20/2026 revealed Resident # 62 had no cognitive impairment, required setup, clean up assistance for eating and oral hygiene, had a Stage 4 Pressure Ulcer, received scheduled pain medication regimen and had moderate occasional pain or hurting at any time in the last 5 days. Record review of Resident # 62's Physician's order sheet revealed orders dated 04/23/2026 for Tramadol HCl oral tablet 50 milligrams *Controlled Drug* give 1 tablet by mouth every day shift for pain 30 minutes before wound care. Review of the May 2026 Medication Administration Record revealed the Tramadol HCl oral tablet 50 mg 30 minutes before wound care order omitted signatures on: 05/02/2026, 05/03/2026, 05/09/2026, and 05/10/2026. Signatures with code "4" on the dates: 05/04/2026 to 05/06/2026 and 05/11/2026 indicated "out of parameters" signed by Staff E, Registered Nurse and no progress note was associated with these entries. Record review of the May 2026 Treatment Record revealed daily signatures for wound care on the day shift. During an interview on 05/13/2026 at 3:34 PM the Wound Care Nurse stated that Resident # 62 had an order for Tramadol pain medication prior to wound care and she checks the Medication Administration Record to ensure the medication was given. "I do wound care for her daily Monday to Friday, and the floor nurse does it on the weekend." Staff E, Registered Nurse, was not present in facility nor available on 05/14/2026 for an interview. On 05/14/2026 at 3:45 PM, the Director of Nursing stated: "The nursing staff are present during the care plan meeting to hear interventions. Nurses are to follow physician orders. If a resident refuses medication the nurse is to document that." Record review of the facility's policy and procedure titled, "Pressure Ulcers/Skin Breakdown - Clinical Protocol" Revised April 2018, Reviewed January	N0101		06/08/2026

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N0101 SS = D	Continued from page 4 2026 indicated: Assessment and Recognition: 2. In addition, the nurse shall describe and document/report the following: b. Pain assessment... Class III	N0101		06/08/2026
N0110 SS = D	Physical Environment - Safe, Clean, Homelike CFR(s): 400.141(1)(h) FS; 59A-4.122(1) FAC 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews and interviews, the facility did not maintain an environment free of accident hazards on one (second floor) of two floors. As evidenced by shaving razors observed in Resident #29's room. Staff disposed of lancets in the regular trash and left a housekeeping cart with germicidal wipes unattended and easily accessible. There were 94 residents residing in the facility at the time of the survey. The findings included: 1) An observation on 05/11/2026 at 10:47 AM revealed a shaving razor on the sink in resident #29's. Staff E, Licensed Practical Nurse (LPN) was made aware and entered the room and removed the razor from the sink. At that time, Resident # 29 entered the room and Staff E, LPN asked the resident if the razor belonged to him and Resident # 29 stated: "That is not my razor. I keep my razors in the nightstand." At that time, the resident showed the surveyor and Staff E, LPN the shaving razors he kept in the nightstand (Photographic evidence). Staff E, LPN then exited the room. On 05/11/2026 at 10:50 AM, the surveyor asked	N0110	The facility continues to ensure that the resident environment remains free of accident hazards as possible. IMMEDIATE CORRECTIVE ACTION Resident #29 was not adversely affected by the alleged deficient practice. Razor was immediately removed and disposed of from resident's room by nurse on 5/11/26. Germicidal wipes were immediately secured in a locked housekeeping cart on 5/11/26. Staff E was provided with 1:1 education by the Director of Nursing regarding the importance of providing an environment free from hazards and accidents with emphasis on keeping hazardous items like razor secured on 5/11/26. Staff G was provided with 1 to 1 education by House Keeping Director regarding ensuring that all housekeeping chemical products are secured in a locked housekeeping cart when not in use on 5/12/2026. IDENTIFICATION OF OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED All active residents in the facility can potentially be affected by the alleged deficient practice. The Director of Nursing and/ designee conducted a facility-wide observation audit to ensure that hazardous items are locked and secured and that staff are disposing of Sharps in a Sharp Resistant Container on 05/15/2026. The Housekeeping Director conducted a facility-wide observation on 5/15/2026 to ensure that all housekeeping chemical products were secured and locked inside the housekeeping cart when not in use.	06/08/2026

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N0110 SS = D	Continued from page 5 Staff E, Licensed Practical Nurse if residents were allowed to keep shaving razors in the room unattended. Staff E, LPN responded, "No," and went back to Resident # 29's room and retrieved the razors. Review of Resident # 29's clinical records revealed the resident was admitted on 05/04/2025 with diagnosis that included Malignant Neoplasm of overlapping sites of bladder. Record review of Resident # 29's Quarterly Minimum Data Set reference dated 02/18/2026 revealed Resident # 29 had a Brief Interview of Mental status score of 15 out of 15 which indicated the resident had no cognitive impairment. Review of Resident # 29's care plans, initiated on 09/16/2024 and revised on 06/13/2025 for Activities of Daily Living (ADL), indicated the resident had self-care deficits associated with activity intolerance, generalized muscle weakness, bladder cancer, and a history of gross hematuria. The interventions included encouraging and assisting the resident with all ADL tasks as appropriate and tolerated, such as bathing, personal hygiene, and oral care. On 05/11/2026 at 1:47 PM, the Assistant Director of Nursing (ADON) was asked about the facility's policy related to shaving razors and the ADON stated, "We do not allow residents to keep shaving razors in their rooms for safety purposes." On 05/14/2026 at 11:54 AM the Administrator/Risk Manager stated, "I review safety protocols and interventions. Residents are not allowed to keep the shaving razors in the rooms and staff are to keep the razor in the supply room." On 05/14/2026 at 3:48 PM, the Director of Nursing stated: "Residents cannot keep shaving razors in rooms." 2) On 05/11/2026 at 11:09 AM, a blood glucose check was conducted by Staff E, LPN, for Resident #4. Upon completion of the procedure, Staff E, LPN discarded the unused lancets in the medication cart trash (Photographic evidence). On 05/11/2026 at 11:40 AM Staff E, LPN was asked about the facility's policy and procedure regarding the proper disposal of unused lancets; Staff E stated: "Lancets are to be disposed of into the sharp resistant container for safety purposes." Staff E did not respond when asked why the lancets were	N0110	Continued from page 5 No residents were adversely affected by the alleged deficient practice SYSTEMATIC CHANGES Director of Nursing initiated ongoing in-service education with staff on standards of maintaining an environment free from hazards/accidents with emphasis on keeping hazardous items like razor secured and properly disposing of sharps in sharps resistant container on 5/20/26. The Housekeeping Director and/or designee initiated ongoing in-service education on standards of maintaining an environment free from hazards/accidents with emphasis on keeping housekeeping chemical products secured and locked in a housekeeping cart when not in use on 5/20/2026. MONITORING The Director of Nursing and/or designee will conduct random observation audits to ensure that hazardous items are locked and secured and sharps are disposed in sharps resistant container weekly for 3 months. The Housekeeping Director and/or designee will conduct random observation audits to ensure that housekeeping chemical products are secured and locked in a housekeeping cart weekly for 3 months. The Director of Nursing, Housekeeping Director and/or designee will report findings of observation/audits to the quality assurance committee monthly for 3 months to ensure continued substantial compliance is achieved and maintained.	06/08/2026

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N0110 SS = D	Continued from page 6 disposed of into regular trash. On 05/11/2026 at 5:42 PM the Director of Nursing (DON) stated, "Nurses are expected to dispose of used and unused sharps into the sharps container for safety purposes." 3) During an observation conducted on 05/11/2026 at 11:39 AM on the facility's second floor, it was noted that the unattended housekeeping cart located on the west side had a container of germicidal wipes placed atop the cart, with easy access (Photo evidence). On 05/13/ 2026, at 9:45 AM, a follow-up observation on the facility's second floor revealed a container of germicidal wipes was left unattended on top of the housekeeping cart on the west side hallway. (Photo evidence) On 05/11/2026 at 3:47 PM the Corporate Housekeeping staff and the facility's Housekeeping Director revealed the facility has four housekeeping carts and everything related to chemicals that could harm the resident should be locked in the compartment on the cart and the housekeeping and the housekeeping staff have the key. On 05/13/2026 at 9:50 AM, the Housekeeping Director and the Assistant Director of Nursing were made aware of the identified concerns and acknowledged the wipes should not be kept unattended on top of the cart. On 5/13/26 at 1:09 PM Staff G, housekeeping staff stated, "I keep disinfectant wipes and cleaning supplies locked in the cart for the safety of residents." Record review of the facility's policy titled, "Nursing Home Accident Prevention and Safety Policy" Effective Date: August 1, 2021, Review Date: January 3, 2026, revealed: Purpose The purpose of this policy is to establish procedures that promote a safe environment for residents, staff, visitors, and contractors within the nursing home. This policy aims to prevent accidents, reduce injuries, ensure prompt response to emergencies, and maintain compliance with federal, state, and local safety regulations. Policy Statement:	N0110		06/08/2026

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N0110 SS = D	Continued from page 7 The nursing facility is committed to: Maintaining a safe and hazard-free environment. Preventing accidents and injuries. Identifying and correcting safety risks promptly. Providing staff education and training on safety practices. Ensuring timely reporting and investigation of incidents. Promoting resident rights, dignity, and well-being. All staff members are responsible for complying with safety procedures and reporting on unsafe conditions immediately. Class III	N0110		06/08/2026

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F0000	INITIAL COMMENTS An unannounced recertification survey was conducted at Biscayne Health and Rehabilitation Center on May 11, 2026, through May 14, 2026. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities. The following is a description of the non-compliance.	F0000		06/08/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews and interviews, the facility did not maintain an environment free of accident hazards on one (second floor) of two floors. As evidenced by shaving razors observed in Resident #29's room. Staff disposed of lancets in the regular trash and left a housekeeping cart with germicidal wipes unattended and easily accessible. There were 94 residents residing in the facility at the time of the survey. The findings included. 1) An observation on 05/11/2026 at 10:47 AM revealed a shaving razor on the sink in resident #29's. Staff E, Licensed Practical Nurse (LPN) was made aware and entered the room and removed the	F0689	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the terms or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of the Federal and State laws. The facility continues to ensure that the resident environment remains free of accident hazards as possible. IMMEDIATE CORRECTIVE ACTION Resident #29 was not adversely affected by the alleged deficient practice. Razor was immediately removed and disposed of from resident's room by nurse on 5/11/26. Germicidal wipes were immediately secured in a locked housekeeping cart on 5/11/26. Staff E was provided with 1:1 education by the Director of Nursing regarding the importance of providing an environment free from hazards and accidents with emphasis on keeping hazardous items like razor secured on 5/11/26. Staff G was provided with 1 to 1 education by House Keeping Director regarding ensuring that all housekeeping chemical products are secured in a locked housekeeping cart when not in use on 5/12/2026. IDENTIFICATION OF OTHER RESIDENTS HAVING	06/08/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0689 SS = D	Continued from page 1 razor from the sink. At that time, Resident # 29 entered the room and Staff E, LPN asked the resident if the razor belonged to him and Resident # 29 stated: "That is not my razor. I keep my razors in the nightstand." At that time, the resident showed the surveyor and Staff E, LPN the shaving razors he kept in the nightstand (Photographic evidence). Staff E, LPN then exited the room. On 05/11/2026 at 10:50 AM, the surveyor asked Staff E, Licensed Practical Nurse if residents were allowed to keep shaving razors in the room unattended. Staff E, LPN responded, "No," and went back to Resident # 29's room and retrieved the razors. Review of Resident # 29's clinical records revealed the resident was admitted on 05/04/2025 with diagnosis that included Malignant Neoplasm of overlapping sites of bladder. Record review of Resident # 29's Quarterly Minimum Data Set reference dated 02/18/2026 revealed Resident # 29 had a Brief Interview of Mental status score of 15 out of 15 which indicated the resident had no cognitive impairment. Review of Resident # 29's care plans, initiated on 09/16/2024 and revised on 06/13/2025 for Activities of Daily Living (ADL), indicated the resident had self-care deficits associated with activity intolerance, generalized muscle weakness, bladder cancer, and a history of gross hematuria. The interventions included encouraging and assisting the resident with all ADL tasks as appropriate and tolerated, such as bathing, personal hygiene, and oral care. On 05/11/2026 at 1:47 PM, the Assistant Director of Nursing (ADON) was asked about the facility's policy related to shaving razors and the ADON stated, "We do not allow residents to keep shaving razors in their rooms for safety purposes." On 05/14/2026 at 11:54 AM the Administrator/Risk Manager stated, "I review safety protocols and interventions. Residents are not allowed to keep the shaving razors in the rooms and staff are to keep the razor in the supply room." On 05/14/2026 at 3:48 PM, the Director of Nursing stated: "Residents cannot keep shaving razors in rooms." 2) On 05/11/2026 at 11:09 AM, a blood glucose check was conducted by Staff E, LPN, for Resident	F0689	Continued from page 1 POTENTIAL TO BE AFFECTED All active residents in the facility can potentially be affected by the alleged deficient practice. The Director of Nursing and/ designee conducted a facility-wide observation audit to ensure that hazardous items are locked and secured and that staff are disposing of Sharps in a Sharp Resistant Container on 05/15/2026. The Housekeeping Director conducted a facility-wide observation on 5/15/2026 to ensure that all housekeeping chemical products were secured and locked inside the housekeeping cart when not in use. No residents were adversely affected by the alleged deficient practice. SYSTEMATIC CHANGES Director of Nursing initiated ongoing in-service education with staff on standards of maintaining an environment free from hazards/accidents with emphasis on keeping hazardous items like razor secured and properly disposing of sharps in sharps resistant container on 5/20/26. The Housekeeping Director and/or designee initiated ongoing in-service education on standards of maintaining an environment free from hazards/accidents with emphasis on keeping housekeeping chemical products secured and locked in a housekeeping cart when not in use on 5/20/2026. MONITORING The Director of Nursing and/or designee will conduct random observation audits to ensure that hazardous items are locked and secured and sharps are disposed in sharps resistant container weekly for 3 months. The Housekeeping Director and/or designee will conduct random observation audits to ensure that housekeeping chemical products are secured and locked in a housekeeping cart weekly for 3 months.	06/08/2026

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	105008	A. BUILDING B. WING	05/14/2026

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F0689 SS = D	Continued from page 2 #4. Upon completion of the procedure, Staff E, LPN discarded the unused lancets in the medication cart trash (Photographic evidence). On 05/11/2026 at 11:40 AM Staff E, LPN was asked about the facility's policy and procedure regarding the proper disposal of unused lancets; Staff E stated: "Lancets are to be disposed of into the sharp resistant container for safety purposes." Staff E did not respond when asked why the lancets were disposed of into regular trash. On 05/11/2026 at 5:42 PM the Director of Nursing (DON) stated, "Nurses are expected to dispose of used and unused sharps into the sharps container for safety purposes." 3) During an observation conducted on 05/11/2026 at 11:39 AM on the facility's second floor, it was noted that the unattended housekeeping cart located on the west side had a container of germicidal wipes placed atop the cart, with easy access (Photo evidence). On 05/13/ 2026, at 9:45 AM, a follow-up observation on the facility's second floor revealed a container of germicidal wipes was left unattended on top of the housekeeping cart on the west side hallway. (Photo evidence) On 05/11/2026 at 3:47 PM the Corporate Housekeeping staff and the facility's Housekeeping Director revealed the facility has four housekeeping carts and everything related to chemicals that could harm the resident should be locked in the compartment on the cart and the housekeeping and the housekeeping staff have the key. On 05/13/2026 at 9:50 AM, the Housekeeping Director and the Assistant Director of Nursing were made aware of the identified concerns and acknowledged the wipes should not be kept unattended on top of the cart. On 5/13/26 at 1:09 PM Staff G, housekeeping staff stated, "I keep disinfectant wipes and cleaning supplies locked in the cart for the safety of residents." Record review of the facility's policy titled, "Nursing Home Accident Prevention and Safety Policy" Effective Date: August 1, 2021, Review Date: January 3, 2026, revealed: Purpose	F0689	Continued from page 2 The Director of Nursing, Housekeeping Director and/or designee will report findings of observation/audits to the quality assurance committee monthly for 3 months to ensure continued substantial compliance is achieved and maintained.	06/08/2026

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F0689 SS = D	Continued from page 3 The purpose of this policy is to establish procedures that promote a safe environment for residents, staff, visitors, and contractors within the nursing home. This policy aims to prevent accidents, reduce injuries, ensure prompt response to emergencies, and maintain compliance with federal, state, and local safety regulations. Policy Statement: The nursing facility is committed to: Maintaining a safe and hazard-free environment. Preventing accidents and injuries. Identifying and correcting safety risks promptly. Providing staff education and training on safety practices. Ensuring timely reporting and investigation of incidents. Promoting resident rights, dignity, and well-being. All staff members are responsible for complying with safety procedures and reporting on unsafe conditions immediately.	F0689		06/08/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F0761	The facility continues to ensure that all drugs and biologicals are stored appropriately. IMMEDIATE CORRECTIVE ACTION Medications were immediately removed from room for residents #58, #20, and #29 on 5/11/26. Residents #58, #20, and #29 were not adversely affected by alleged deficient practice. IDENTIFICATION OF OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED All active residents in the facility can potentially be affected by the alleged deficient practice. No residents were adversely affected by the alleged deficient practice. Director of Nursing and/or designee conducted a facility-wide observation audit to ensure that drugs and biologicals are stored appropriately on 05/12/2026. SYSTEMATIC CHANGES The Director of Nursing and/or designee initiated ongoing in-service education with staff on standards	06/08/2026

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F0761 SS = D	Continued from page 4 This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and interviews, the facility did not adhere to proper medication storage protocols on the second floor, as evidenced by medicated ointments observed in the rooms of Resident #58, Resident #20, and Resident #29. The findings include: 1) Observation on 05/11/2026 at 9:07 AM revealed a container of Diclofenac ointment on top of the sink in Resident # 58's room (Photographic evidence). Review of Resident #58's clinical records revealed the resident was admitted on 07/19/2025 with diagnosis that included: Heart Failure and had no cognitive impairment. 2) Observation on 05/11/2026 at 9:39 AM and on 05/12/2026 at 11:06 AM a tube of Hydrophilic wound dressing was noted in a basket on Resident # 20's nightstand. (Photo evidence). Review of Resident # 20's clinical records revealed the resident was admitted on 07/19/2025 with diagnosis that included: Cerebral infarction due to embolism of right middle cerebral artery and was severely cognitively impaired. 3) Observation on 05/11/2026 at 10:54 AM revealed a container of Ciclopirox Topical solution on Resident # 29's nightstand. (Photo evidence). Review of Resident #29's clinical record revealed the resident was admitted on 05/04/2025 with diagnosis that included: Malignant neoplasm of overlapping sites of bladder and had no cognitive impairment. Record review of the facility's policy titled, "Storage of Medications" revised January 2026 revealed Policy: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. On 05/11/2026 at 11:18 AM Staff E, Licensed Practical Nurse (LPN) was made aware of the identified concerns. Staff E LPN stated:	F0761	Continued from page 4 of drug and biological storage on 05/20/2026. MONITORING Nursing Supervisor and/or designee will conduct random observation audits to ensure drugs and biologicals are stored appropriately, 5 days a week for 1 month, then weekly for 3 months. The Director of Nursing and/or designee will report findings of observation/audits to the quality assurance committee monthly for 4 months to ensure continued substantial compliance.	06/08/2026

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F0761 SS = D	Continued from page 5 "Medications and ointments are kept on the locked cart and not allowed at the bedside. Sometimes family brings them in. We do rounds and remove any ointment at the bedside." On 05/11/2026 at 12:16 PM, the Wound care nurse stated: "I put all the creams, ointments, and medicated nail polish back into the treatment cart after providing treatment." On 05/11/2026 at 1:07 PM, Staff D, Certified Nursing Assistant stated: "When I do rounds, I look to make sure the resident is safe. If I see any objects that can harm the residents like razors or a knife I remove them. If I see medications in the room, I tell the nurse." On 05/11/2026 at 1:25 PM the Assistant Director of Nursing was made aware of the identified concerns and stated: "Residents are not allowed to keep any medications in the room. We keep all medications in the cart for the safety of residents."	F0761		06/08/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F0842	The facility continues to ensure that resident's medical records are complete and accurately documented. IMMEDIATE CORRECTIVE ACTION Resident #62 was assessed by Director of Nursing upon notification of surveyor and resident #62 did not have any adverse outcome related to the alleged deficient practice on 5/13/26. IDENTIFICATION OF OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED All active residents in the facility can potentially be affected by the alleged deficient practice. Director of Nursing and/or designee conducted a comprehensive chart audit to ensure that residents with pain medications were accurately documented on EMAR on 5/15/26. No residents were adversely affected by the alleged deficient practice. SYSTEMATIC CHANGES The Director of Nursing and/or designee initiated	06/08/2026

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F0842 SS = D	Continued from page 6 §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F0842	Continued from page 6 ongoing in-service education with clinical staff on standards of accurate medication administration documentation with emphasis on accurate documentation of Pain Medication Refusal. MONITORING Nursing Supervisor and/or designee will conduct random observation audits to ensure accurate documentation of pain medication administration and refusal, 5 days a week for 1 month, then weekly for 3 months. The Director of Nursing and/or designee will report findings of observation/audits to the quality assurance committee monthly for 4 months to ensure continued substantial compliance is achieved and maintained.	06/08/2026

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F0842 SS = D	Continued from page 7 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observations, records reviewed and interviews the facility failed to document adequate information in the medical records for one (Resident # 62) out of two sampled residents with a pressure ulcer. Staff did not sign the Medication Administration Record for pain medication ordered before wound care on several dates in May 2026 for Resident # 62, even though wound care was provided on those days. Five residents with pressure ulcers lived in the facility at the time of the survey. The findings included. During observation on 05/13/2026 at 10:02 AM of Resident # 62's wound care being performed by the facility's Wound Care Nurse and Resident # 62 denied pain at that time. Record review of Resident # 62's clinical record revealed the resident was admitted to the facility on 11/04/2025 with diagnosis that included but not limited to Peripheral Vascular Disease. Review of Resident # 62's care plans that started on 04/13/2026 and revised on 05/05/2026 for a pressure ulcer with interventions that included: Administer medications and treatments as ordered by the medical doctor. Record review of Resident #62's significant change Minimum Data Set reference dated 04/20/2026 revealed Resident # 62 had no cognitive impairment, required setup, clean up assistance for eating and oral hygiene, had a Stage 4 Pressure Ulcer, received scheduled pain medication regimen and had moderate occasional pain or hurting at any time in the last 5 days. Record review of Resident # 62's Physician's order sheet revealed orders dated 04/23/2026 for Tramadol HCl oral tablet 50 milligrams *Controlled Drug* give 1 tablet by mouth every day shift for pain 30 minutes before wound care. Review of the May 2026 Medication Administration	F0842		06/08/2026

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F0842 SS = D	Continued from page 8 Record revealed the Tramadol HCl oral tablet 50 mg 30 minutes before wound care order omitted signatures on: 05/02/2026, 05/03/2026, 05/09/2026, and 05/10/2026. Signatures with code "4" on the dates: 05/04/2026 to 05/06/2026 and 05/11/2026 indicated "out of parameters" signed by Staff E, Registered Nurse and no progress note was associated with these entries. Record review of the May 2026 Treatment Record revealed daily signatures for wound care on the day shift. During an interview on 05/13/2026 at 3:34 PM the Wound Care Nurse stated that Resident # 62 had an order for Tramadol pain medication prior to wound care and she checks the Medication Administration Record to ensure the medication was given. "I do wound care for her daily Monday to Friday, and the floor nurse does it on the weekend." Staff E, Registered Nurse, was not present in facility nor available on 05/14/2026 for an interview. On 05/14/2026 at 3:45 PM, the Director of Nursing stated, "The nursing staff are present during the care plan meeting to hear interventions. Nurses are to follow physician orders. If a resident refuses medication the nurse is to document that." Record review of the facility's policy and procedure titled, "Pressure Ulcers/Skin Breakdown - Clinical Protocol" Revised April 2018, Reviewed January 2026 indicated: Assessment and Recognition: 2. In addition, the nurse shall describe and document/report the following: b. Pain assessment...	F0842		06/08/2026
F0867 SS = D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective	F0867	The facility continues to ensure that the quality assurance and improvement program is used to identify and track areas for improvement throughout the facility. IMMEDIATE CORRECTIVE ACTION Ad hoc QA meeting performed on 5/15/26 to address QAPI/QAA concerns and plan of action for current alleged deficiencies including alleged noncompliance with QAPI/QAA Improvement Activities. IDENTIFICATION OF OTHER RESIDENTS HAVING	06/08/2026

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F0867 SS = D	Continued from page 9 systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure	F0867	Continued from page 9 POTENTIAL TO BE AFFECTED All active residents in the facility can potentially be affected by the alleged deficient practice. Administrator/Risk Manager reviewed and audited previous 6 months of QA meetings on 5/18/26 to ensure areas of concern were addressed. SYSTEMATIC CHANGES On 5/19/26, ongoing in-services was conducted by Regional Consultant with facility Quality Assurance Committee about Quality Assurance and Performance Improvement Policy with emphasis on implementation, monitoring, and evaluation of performance improvement projects. The Quality Assessment and Assurance Committee will meet monthly and conduct random audit of 1 current performance improvement project monthly to validate reported substantial compliance. MONITORING The Interdisciplinary Team as well as Regional Consultant will attend monthly QAPI meeting to ensure QAA Committee compliance with QAPI process. Regional Consultant will assist with random audit process for 3 months. Any and all findings will be reported during monthly quality assurance meeting until substantial compliance is achieved.	06/08/2026

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F0867 SS = D	Continued from page 10 that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F0867		06/08/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0867 SS = D	Continued from page 11 This REQUIREMENT is NOT MET as evidenced by: Based on observations, interview and record review, the facility's Quality Assurance and Performance Improvement Activities (QAPI/QAA) failed to demonstrate an effective plan of action to correct repeated deficiencies in the problem area as evidenced by repeated deficient practices for F0761; failed to properly store medications. There were 94 residents residing in the facility at the time of survey. The findings included: Record reviews of the facility's survey history revealed the facility was cited F 0761 during the recertification and Re-licensure survey with an exit date of October 31, 2024. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 02/10/2026, 03/10/2026 and 04/14/2026 revealed the facility had a QAA Committee meeting monthly and attendees included: Administrator, Director of Nursing (DON), Medical Director, and other department heads. Record review of the facility's Policy and Procedure titled, "Quality Assurance and Performance Improvement" Date Implemented: 9/1/2022 Date Reviewed/ Revised: 1/1/2026 revealed: Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Policy Explanation and Compliance Guidelines: 2. The QA Committee shall be interdisciplinary and shall: Develop and implement appropriate plans of action to correct identified quality deficiencies. During an interview on 05/14/2026 at 4:50 PM the Administrator stated, "The members include Medical Director, Nursing home administrator, other department heads and we invite direct care staff members. We meet monthly and as needed to assess ways to make improvements." The Administrator was informed of identified	F0867		06/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105008	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

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F0867 SS = D	Continued from page 12 concerns related to repeated deficiencies and the Quality Assurance and Performance Improvement activities.	F0867		06/08/2026
F0919 SS = A	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interviews, the facility failed to provide a functioning call system for Resident #68 as evidenced by three observations of Resident #68's call light not functioning and her bell not within reach. There were 94 residents residing in the facility at the time of survey. The findings include: Observation on 05/11/2026 at 9:03 AM, 05/12/2026 at 9:51 AM and on 05/13/2026 at 10:51 AM revealed Resident #68's call light was nearby but was not functioning. The resident's bell was seen on top of the mini refrigerator beside the bed. Record review of Resident #68's clinical records revealed the resident was admitted to the facility on 09/01/2020. Clinical diagnoses include but are not limited to: Aphasia following cerebral infarction. Record review of Resident #68's Care Plan for May 2026 revealed self -care deficit and requires Activities of Daily Living (ADL) assistances with most of her ADL's. Interventions include - Encouraging the resident to participate in daily care, allowing independency as able and intervene/assist only to level needed and fall/safety precaution.	F0919		06/08/2026

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	105008	A. BUILDING B. WING	05/14/2026

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F0919 SS = A	Continued from page 13 Record review of the Annual Minimum Data Set (MDS) dated 03/26/2026 revealed in Section C for Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of a 00 which indicates the resident is cognitively impaired. Section GG for Functional Abilities revealed dependence on toileting and lower body dressing, set up assistance for eating, partial assistance for upper body dressing and substantial assistance for showering and sit to lying. During an interview on 05/13/2026 at 12:58 PM Staff A, Maintenance Director stated: "I was not aware of [Resident #68] call light not operating. I am going to get it fixed now. Frequent rounds on residents' equipment is a part of the guardian angel program which the department heads are assigned certain equipment to make sure it is operating properly. We insert work orders in our [maintenance software] program." During an interview on 05/13/2026 at 1:04 PM the Administrator stated: "The bells at the bedside are more for preferences. The resident has the choice to use the bell or call light but not because the call light is not working. The maintenance will check to see if it is an issue with the cord and replace it. We upload work orders in the [maintenance software] program electronically." During an interview on 05/13/2026 at 2:56 PM with Staff B, Certified Nursing Assistant (CNA) stated "Before leaving the resident's room, I make sure the call light is positioned on the side where the resident can easily access it and within reach at all times. If the call light is not working, I report it immediately to the nurse, and the nurse follows up by reporting it to maintenance or the appropriate department for repair." Record review of the facility's undated policy indicated: 1. Installation and Maintenance: Each resident room will be equipped with bedside, toilet, and shower call devices, fully functional and within reach of residents with varying mobility or disability. Call light systems must have audible and visual alerts at staff workstations and portable staff devices. Systems shall be tested upon installation, monthly, and after any maintenance.	F0919		06/08/2026

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F0919 SS = A	Continued from page 14 2. Accessibility: Devices must be easily reachable from beds, chairs, and floors in bathrooms or showers.	F0919		06/08/2026